August 23, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0902-01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating physician. Your case was reviewed by a physician reviewer who is Board Certified in Physical Medicine and Rehabilitation.

THE PHYSICIAN REVIEWER OF YOUR CASE **AGREES** WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE. **The reviewer has determined that a twenty (20) day pain management program is not medically necessary in this case.**

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on August 23, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is ___ for ___. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0902-01, in the area of Physical Medicine and Rehabilitation. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of a 20-day pain management program.
2. Correspondence from the requesting agent.
3. History and physical and office notes.
4. Functional capacity evaluation.
5. Radiology reports.
6. Multiple clinical assessments of ___.
7. Electrodiagnostic results.
8. Chiropractic assessment.

B. BRIEF CLINICAL HISTORY:

This is a 23-year-old gentleman who apparently was catching some sort of cement blocks being tossed from a truck. This caused him to twist his left knee and fall to his knee. He then reportedly developed knee pain, cervical spine pain, thoracic spine pain, lumbar spine pain, and a variety of complaints. He was initially seen by ___ who determined there were multiple soft tissue spine sprain/strain type symptoms. He was also evaluated by an assistant to ___, ___, who started a chiropractic program of adjustments of the cervical, thoracic, and lumbar spine.

Additionally, he was evaluated by ___, an emergency medicine/ occupational medicine/family medicine provider in ___, who made a diagnosis of multiple strain of the cervical spine, thoracic spine, and lumbar spine; rule out cervical, thoracic, and lumbar herniated disk; left knee sprain; rule out internal derangement.

An electrodiagnostic evaluation was completed which noted no specific changes. However, there was one comment regarding moderate reduction in the left tibial nerve motor conduction velocity in the right knee, the significance of which is not clear. However, it was abundantly clear that there was no evidence of abnormality on the EMG.

He was also placed into a work hardening program, and there was no change in his complaints or physical findings subsequent to that program.

MRI scanning of the lumbar spine noted a normal spine, with no abnormalities or displacement. There was some disk desiccation, i.e., degenerative changes and a slight broad-based protrusion at L5-S1. However, there was no mention of a specific disk herniation.

In addition, there was an evaluation by ___, who felt there was an atypical depression, chronic pain, and a GAF score of 55. There was an assessment by ___, indicating the claimant for a chronic pain program.

C. DISPUTED SERVICES:

A 20-day pain management program.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

With any treatment plan, there has to be a reasonable expectation of success or improvement in the case. This is a 23-year-old gentleman who has a mild disk bulge and has complaints far exceeding the reported mechanism of injury. Moreover, subsequent to the initial complaint of knee pain, no one has addressed any issue relative to the knee. There was no mention of cervical sprain or thoracic sprain after the initial chiropractic assessment. Additionally, all treatment modalities attempted have been unsuccessful, to include conservative care with chiropractic manipulation, physical therapy, work hardening, and other modalities. There has been no indication of the efficacy of any of these treatment modalities. Therefore, one cannot expect this intensive chronic pain program would have any effect in this case.

I do note in the Request for Review that the provider for the pain management program is citing the health treatment guidelines which have been withdrawn by TWCC and are no longer in effect.

Therefore, given the failure of all conservative modalities, given the failure of work hardening, physical therapy, and medications to ameliorate the symptomatology in this case, there is no indication that this intensive program will have any other basis for success, and there is no clinical indication that this program would help this individual achieve maximum medical improvement.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 13 August 2002